



REQUEST FOR STUDENT INCOME AND EXPENSES

State Form 42755 (R5 / 1-08) / FI 2203

Date (month, day, year)

*SOCIAL SECURITY NUMBER

This State agency is requesting disclosure of your Social Security number, under IC 4-1-8-1, in order to perform its statutory function. Disclosure is mandatory and this form will not be processed without it.

NOTICE OF CONFIDENTIALITY

The information obtained on this form is confidential under state and federal regulations, including 470 IAC 1-2-7, 470 IAC 1-3-1, 470 IAC 6-1-1, 405 IAC 1-1-12, 45 CFR 205.50, 7 CFR 272.1 (c), and 42 CFR 431.300. This information will not be released except as permitted or required by law or with the consent of the applicant / recipient whose signature appears below.

TO: (name and address of school)

RE:

Name of student

Case number

Case name (if different)

ATTENTION: Financial Aid Office

Dear Sir or Madam:

The student referenced above is part of a household which has applied for or currently receives benefits from one or more of the following programs: Temporary Assistance for Needy Families (TANF), Food Stamps and/or Medicaid. In order to determine the eligibility and/or benefit level for this household, information concerning financial aid must be obtained from your office. This information will be used only for the purpose of determining if any income must be included in budgetary calculations required by these programs.

Please complete the appropriate information requested on the reverse side of this letter and return this form as soon as possible to the County Office of Family Resources indicated below.

Thank you for your cooperation in this matter.

Sincerely,

Signature of worker

ID number

Telephone number

()

I hereby authorize _____ to release information about my
Name of institution
financial aid which is necessary to determine my household's eligibility for Food Stamps / TANF / Medicaid.

Signature of student

*Social Security number

XXX - XX -

RETURN TO:

County Office of Family Resources

Address (number and street)

City, state and ZIP code

ATTENTION:

FOLD

FOLD

Name of student	*Social Security number
-----------------	-------------------------

I. ENROLLMENT		
The student attends: <input type="checkbox"/> less than 1/2 time <input type="checkbox"/> 1/2 time or more		The student is enrolled in a <input type="checkbox"/> graduate or <input type="checkbox"/> undergraduate program
Is a GED or diploma required for enrollment in school? <input type="checkbox"/> Yes <input type="checkbox"/> No		If No, in student's curriculum? <input type="checkbox"/> Yes <input type="checkbox"/> No

II. TYPE OF STUDENT ASSISTANCE / EXPENSES						
Name of Assistance	Date Income Disbursed to the Student	Months Involved in Period Provided for (whole or part)	Total Amount	Expenses		
				Tuition	Mandatory Fees Charged by School	Origination & Insurance Fees on Loan
PELL Grant	___ / ___ / ___	_____ thru _____	\$ _____	\$ _____	\$ _____	\$ _____
Educational loan Name: _____	___ / ___ / ___	_____ thru _____	\$ _____	\$ _____	\$ _____	\$ _____
Other Name: _____	___ / ___ / ___	_____ thru _____	\$ _____	\$ _____	\$ _____	\$ _____
Other Name: _____	___ / ___ / ___	_____ thru _____	\$ _____	\$ _____	\$ _____	\$ _____
VA Benefits Name: _____	___ / ___ / ___	_____ thru _____	\$ _____	\$ _____	\$ _____	\$ _____

III. WORK STUDY PARTICIPATION	
Date participation begins (month, day, year)	Date participation ends (month, day, year)
<input type="checkbox"/> Paid on _____ or <input type="checkbox"/> Pay date varies <small>Day of week / date(s) during month</small>	
<input type="checkbox"/> Gross amount received is \$ _____ or <input type="checkbox"/> Gross amount varies	
Paid: <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Semi-monthly <input type="checkbox"/> Monthly	

IV. ADDITIONAL EXPENSES		
Please list below any amount of assistance listed in Section II and III that is earmarked for fees, books, supplies, tranportation and other miscellaneous personal expenses (<i>other than living expenses; shelter, clothing and food</i>) incidental to attending your institution. If funds are earmarked for dependent care please list separately.		
Expense	Months Involved	Amount
	_____ thru _____	\$ _____
	_____ thru _____	\$ _____
	_____ thru _____	\$ _____
	_____ thru _____	\$ _____
	_____ thru _____	\$ _____
Signature of person completing this form		Date (month, day, year)